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EVALUATION REPORT 251

ISCRR
Institute for Safety, Compensation and Recovery Research

Evaluation of the Vicarious Trauma Prevention and Awareness Toolkit

Final evaluation

An evaluation into the effectiveness of the toolkit website in preventing vicarious trauma in the Victorian Public Sector.

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A joint initiative of WorkSafe VICTORIA MONASH University

CONTENTS

LIST OF TABLES

LIST OF FIGURES

LIST OF ACRONYMS

CPSU – Community and Public Sector Union
DFFH – Department of Families, Fairness and Housing
DJCS – Department of Justice and Community Safety
HSR – Health and Safety Representative
ISCRR – Institute for Safety, Compensation and Recovery Research
MHIF – Mental Health Improvement Fund
MOU – Memorandum of Understanding
OH&S – Occupational Health and Safety
TOR – Terms of Reference
VGD – Victorian Government Department
VPS – Victorian Public Sector
VT-ORG – Vicarious Trauma Organisational Readiness Guide
VTPAT – Vicarious Trauma Prevention and Awareness Toolkit or the toolkit
VTT – Vicarious Trauma Toolkit
WSV – WorkSafe Victoria

Institute for Safety, Compensation and Recovery Research (ISCRR) wishes to acknowledge the valuable input provided by the CPSU Project Team and participating staff at the Department of Families, Fairness and Housing and the Department of Justice and Community Safety as well as WorkSafe Victoria. We would also like to acknowledge the invaluable contributions of those with lived experience of vicarious trauma for helping to ensure the pilot and toolkit best meets the needs of those most at risk of vicarious trauma.

EXECUTIVE SUMMARY

Exposure to secondary trauma material is an inherent risk and occupational challenge for many Victorian Public Sector (VPS) workers. In response to this risk, the Community and Public Sector Union (CPSU), funded by the WorkWell Mental Health Improvement Fund (MHIF), revised and adapted the Vicarious Trauma Toolkit (VTT), a model of intervention developed in the United States. The result was the Vicarious Trauma Prevention and Awareness Toolkit (the toolkit), a website resource that aimed to create safer working environments for VPS employees.

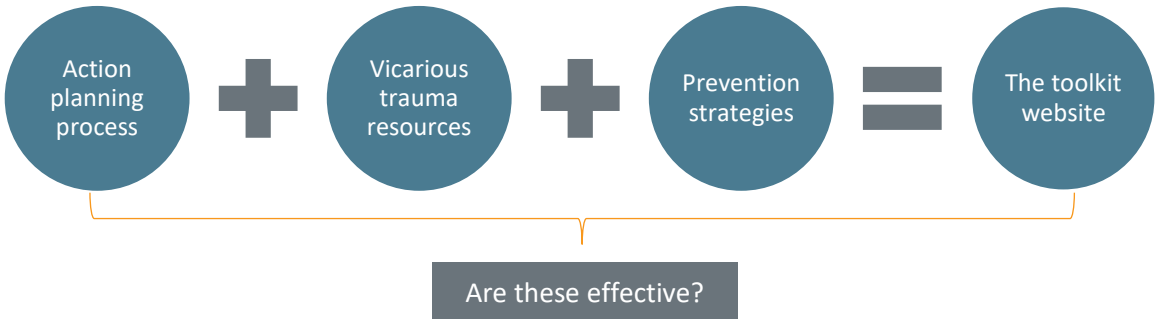
The website included three core components:

1. An action planning process that supports sites to implement a context-specific response
2. Vicarious trauma information and resources
3. Vicarious trauma prevention strategies

The pilot tested the website in six pilot sites from the Department of Justice and Community Safety and the Department of Families, Fairness and Housing. The pilot was implemented from April 2019 to September 2022 and was overseen by a Steering Committee with representatives from project partners. A project team from the CPSU was responsible for implementing the pilot.

Evaluation

The evaluation aimed to determine the effectiveness of the website and its three core components.



The evaluation drew on a mixed methods approach. Action research and co-design methods were used to inform the toolkit development and implementation.

Findings

Effectiveness of the original toolkit website

Early testing with working groups indicated the adapted VTT model and resources from the United States were not appropriate for the VPS audience and were not being used as intended. The project team redesigned the website and launched it in September 2022. The redesigned website was not finalised prior to the evaluation, so determinations of its effectiveness could not be made. The evaluation found that the website addressed an identified need and OHS policy gap by targeting VPS staff exposed to traumatic content and championing primary prevention of vicarious trauma.

1. Action planning process

To develop a context-specific approach to vicarious trauma, each pilot site was guided by the project team through the four steps in the VTT action planning process. Learnings from implementation can be seen in Table 1.

Table 1. Strengths and limitations of the action planning process when applied to pilot sites.

Strengths	Limitations
Step 1: Lay the foundation for success (working group formation and stakeholder engagement)	
Inclusion of frontline staff embedded lived experience knowledge Flexible implementation catered to the varying needs of each site	Balanced representation on the working groups was not consistently achieved Attendance at working groups was inconsistent with high membership turnover Workplace culture impacted on the functioning of working groups Success relied on site champions and active support from management
Step 2: Assess organisational capacity for addressing vicarious trauma (data collection)	
Inclusion of qualitative data was invaluable	Survey results were similar across sites and not relied upon. Pilot sites did not manage data collection and analysis
Step 3: Determine priorities and develop an action plan (action planning)	
Subject matter experts from the project team played a critical role in facilitating action planning	Lack of understanding of vicarious trauma Process was time intensive with sites receiving no extra resourcing to participate in pilot
Step 4: Explore toolkit for resources to implement in your action plan	
Step 4 was not implemented as the toolkit was not available.	

Considerations:

- Working groups were not an effective mode for driving the action planning process in pilot sites. An alternative approach that builds on the strengths of the action planning process needs to be developed.
- It is essential to collect qualitative data for purposes of developing an action plan and preventing vicarious trauma.
- The survey should be modified and applied in the action planning process as a vicarious trauma OHS audit tool instead of survey.
- Toolkit use may need to be facilitated by a subject matter expert who works at the site, department or organisation level.

2. Vicarious trauma knowledge and resources

Participants had mixed levels of knowledge regarding vicarious trauma; for some participants, the pilot was their first introduction to the topic. Much of the training provided by the VPS focused on symptoms and self-help or individual-level strategies such as resilience training.

To address this knowledge gap, the project team provided vicarious trauma training to three teams across three pilot sites. The training aimed to frame exposure to traumatic content as a workplace hazard and vicarious trauma as an OHS risk.

While evaluating the training framework was not in scope of the evaluation, participants reported increases in knowledge and other promising outcomes. Strengths of the training provided were: the

skills of the facilitator, the conversational and inclusive format, and the tailored approach. Recommendations to improve the training were to increase the amount of time allowed for vicarious trauma training.

3. Prevention strategies

Numerous vicarious trauma prevention strategies were identified, however, due to a number of constraints, not all prevention strategies were implemented. Evaluation findings revealed several prevention strategies showing early signs of effectiveness.

Facilitated reflective practice – The pilot sites preferred facilitated reflective practice as it promoted a shared understanding of the impacts of the work and reduced vicarious trauma stigma.

VT acknowledgement – One site implemented a process to formally acknowledge vicarious trauma risk. This included:

- Adding a vicarious trauma question to recruitment interviews and exit interviews
- Providing vicarious trauma resources during onboarding
- Adding a wellbeing plan that includes vicarious trauma for discussion in supervision and performance reviews

The survey scores related to these activities increased from baseline to follow-up. This is consistent with an increased capacity to prevent vicarious trauma at the organisation-level. Focus group participants reported the actions had a de-stigmatising effect and helped to normalise discussion around vicarious trauma in the workplace.

Wellness forums – One pilot site successfully implemented regular wellness forums. Each weekly session covered new content and directly acknowledged the risk inherent in the work. Focus group participants described the sessions contributed to shifting the culture to proactive prevention.

Flexible job descriptions – One pilot site had previously implemented flexible or 'hybrid' job descriptions. This was explained as an effective way to remove or reduce exposure to traumatic content for staff in roles with high levels of exposure.

Psychological Wellbeing Service – This counselling service is available to specific DJCS staff. Participants explained promoting and expanding the service could have a crucial role in preventing vicarious trauma as it directly addressed the risks inherent in the work and considered the work context.

Strategies for further investigation

Any strategies put forward during the pilot that were found to align with current research, align with the MHIF principles, target organisational prevention, and/or fill a gap identified by the pilot have been marked for further research. These include:

- Increase availability of vicarious trauma resources to staff and management
- Use organisation-level wellbeing Key Performance Indicators to demonstrate the organisations commitment to wellbeing
- Develop a vicarious trauma 'reporting system' to help inform staff risk and support needs
- Conduct a vicarious trauma risk assessment for all roles to understand the level of risk inherent in a role and inform job design
- Create vicarious trauma activity sheets with facilitated exercises to be used in team meetings and supervision to promote discussion and shared understanding
- Facilitate a family support forum to increase understanding and support available to staff and families
- Design content warnings to increase awareness of risk and empower staff to control exposure

Conclusion

Findings show that the pilot took a novel and much-needed approach to preventing vicarious trauma. Despite the limitations of the evaluation and the toolkit, the learnings and considerations detailed within the report highlight the important role organisation-level strategies have in preventing vicarious trauma and specific strategies that may contribute to the prevention effort. Combined, the toolkit and the evaluation present an opportunity for the VGD to implement a proactive approach to the prevention of vicarious trauma and to creating safer workplaces for VPS employees.

INTRODUCTION

Background

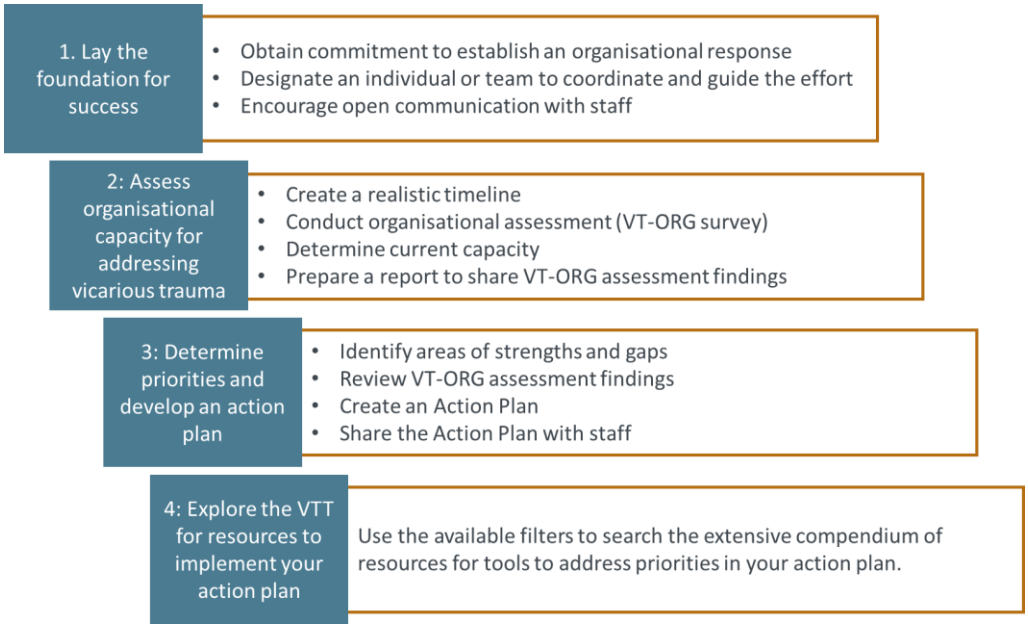
Vicarious trauma can arise from empathic responses to the trauma experiences of others. Often described as 'the cost of caring', vicarious trauma is cumulative and impacts a fundamental shift in worldview or sense of self.[1] For certain occupations, where engaging in traumatic content is an inherent part of the role, the negative consequences from vicarious trauma present a significant risk to workers. Research shows that approximately half of workers indirectly exposed to traumatic content in the course of their work are at risk of mental injury.[2]

Given the significant risks associated with vicarious trauma, the literature about its prevention is vast. Historically, this effort has focused on individual management or self-care strategies, such as meditation or resilience training. While shown to have mixed effectiveness,[3] person-centric approaches have been criticised for their failure to consider workplace context.[4] More recently, research has begun to describe vicarious trauma as an occupational hazard, leading organisations and researchers to consider the role of workplace policy, conditions, and culture.[5]

Research on organisational interventions has found an array of strategies that can reduce the risks associated with vicarious trauma. For example, flexibility in job roles and working conditions, and a supportive work culture that acknowledges the risk inherent in the work are likely to mitigate adverse effects.[3, 6] A workplace-based approach that is multifaceted and tailored to the occupational group or context could be a promising way forward.[3]

The Vicarious Trauma Toolkit (VTT)[7] is an example of an intervention taking an organisation-level, context-specific approach (Figure 1). Developed in 2018 in the United States by Northeastern University's Institute on Urban Health and Research Practice, the VTT is an online resource that contains evidence-based tools, guides, and resources to support organisations to address the vicarious trauma needs specific to their staff and organisation. It also includes the Vicarious Trauma Organisational Readiness Guide (VT-ORG), a fit-for-purpose assessment of the organisations' capacity to address vicarious trauma proactively.[8]

Fig 1. Action planning process underpinning in VTT intervention



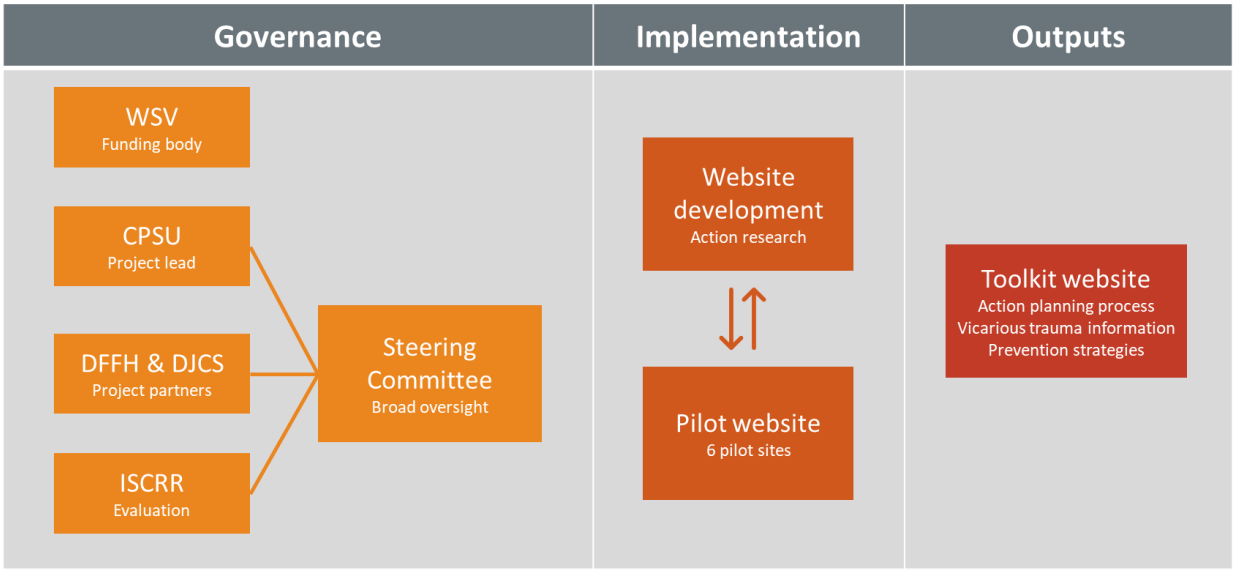
Source: Office for Victims of Crime[7]

Vicarious Trauma Prevention and Awareness Toolkit pilot

Given the breadth of services provided by the Victorian Public Sector (VPS), exposure to secondary traumatic content is an inherent risk and occupational challenge for workers in many departments. In response to this risk, the Community and Public Sector Union (CPSU), funded by the WorkWell Mental Health Improvement Fund (MHIF), aimed to design and pilot a resource that would support the VPS to prevent and mitigate the adverse effects associated with exposure to traumatic content.

The pilot planned to draw on the VTT model and build a replica website tailored for use by the VPS – The Vicarious Trauma Prevention and Awareness Toolkit (the toolkit). The website would then be used and tested by pilot sites and refined throughout the pilot by the project team. An overview of the pilot can be seen in Figure 2 with more detailed aims, key outputs, implementation process and governance described below.

Fig 2. Overview of Vicarious Trauma Prevention and Awareness Toolkit Pilot



Aims of pilot

The aim of the pilot was to create a comprehensive vicarious trauma resource that supports VGDs to prevent and mitigate adverse effects associated with exposure to traumatic content. This would result in safer working environments for VPS employees.

The pilot was underpinned by the six MHIF funding principles:

1. Prevention
2. Creating systems-level change
3. Working in partnership
4. Sustainability of the intervention
5. Knowledge creation and dissemination
6. Encouraging innovation

In line with the MHIF objectives, the pilot focused on primary prevention of vicarious trauma. As can be seen in Figure 3, primary prevention aims to remove the risk before harm is caused, with the sources of work-related stress being the target of such interventions. When exposure to traumatic content is an inherent part of a role or service, the risk of vicarious trauma cannot always be

removed. In such instances, the toolkit promotes addressing systematic or organisation-level factors that can reduce or mitigate the impact of vicarious trauma. For this report, the term organisation-level prevention will be used when referring systematic prevention.

Fig 3. Primary prevention in organisations

From reactive to proactive intervention

Organisations often react once a worker has begun exhibiting signs of distress, rather than identifying hazards early. To target work-related stress, organisations can ensure a balance of proactive (primary), ameliorative (secondary), and reactive (tertiary) strategies.

PREVENTION ⟷ MANAGEMENT

PRIMARY	*SECONDARY*	*TERTIARY*
Objective: to remove or reduce risk factors before psychological harm is caused	*Objective:* to give people the knowledge and skills to cope with stressful work conditions	*Objective:* to treat, support, and rehabilitate employees with a psychological injury
Target: the sources of work-related stress	*Target:* employee responses to stress	*Target:* health impacts of stress and psychological injury

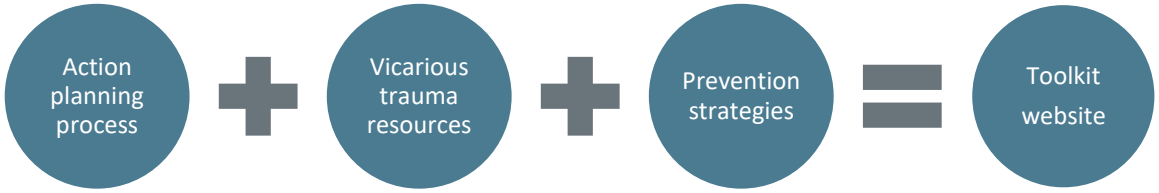
Source: Ikin, Carse & Riley (2019)[9]

Toolkit design

The toolkit was a website tailored to the VPS context that aimed to provide the information needed to develop a context-specific response to vicarious trauma. It was anticipated the website would have three core components:

1. An action planning process that supports pilot sites to implement a context-specific response. This process was modelled on steps described in the VTT (see Figure 1)
2. Vicarious trauma information and resources, including a training framework
3. Prevention strategies that target organisation-level prevention of vicarious trauma

Fig 4. Components of the toolkit website



Pilot implementation

Governance and management

Key project partners supported the implementation of the pilot (see Figure 3).

- CPSU was the project lead responsible for managing the pilot and the associated deliverables.
- WSV via the WorkWell MHIF provided funding and broad oversight to CPSU.
- The Department of Justice and Community Safety (DJCS) and the Department of Families, Fairness and Housing (DFFH, formally the Department of Health and Human Services) played a key role in supporting the implementation of the pilot via the provision of pilot sites and expertise through the participation of Department Representatives on the pilot Steering Committee.
- In line with MHIF funding requirements, a percentage of the pilot budget was allocated to evaluation. An evaluation team from the Institute for Safety, Compensation and Recovery Research (ISCRR) was responsible for the evaluation component.

The implementation of the pilot was overseen by a Steering Committee that included key representatives from each contributing organisation (except for WSV) and select pilot sites (see Figure 2). The Steering Committee met monthly to bi-monthly throughout the pilot and was guided by a Memorandum of Understanding (MOU) and Terms of Reference (TOR).

Pilot sites

A total of six sites were selected to participate in the pilot. Sites were selected based on information provided by Departmental representatives participating in the Steering Committee and CPSU staff working with the respective departments and sites. Selection criteria included variability in:

- Number of employees
- Site location (rural, regional and metropolitan)
- Type of services offered (a variety of client-facing services)

The pilot rollout at each site, including the action planning process, was overseen by a working group. Working groups at each site were formed through an expression of interest process. The majority of working groups included representation from:

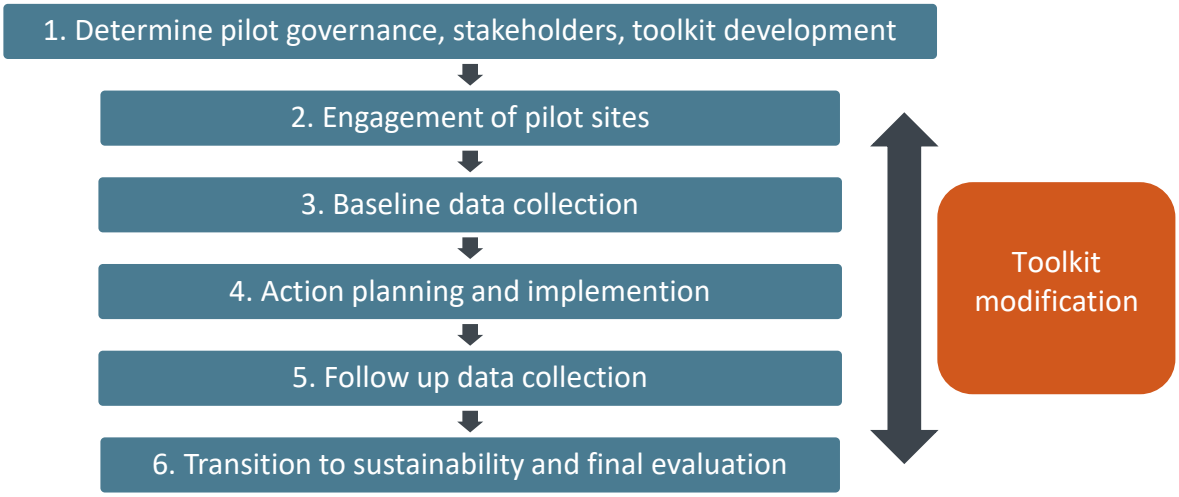
- Site-level management with decision-making capacity
- Health and Safety Representative (HSR) or Occupational Health and Safety (OHS) representatives
- Client-facing staff
- A member of staff from each participating business unit or service
- Subject Matter Experts in vicarious trauma and OHS (from the CPSU project team)

Each working group provided advice to the project team on the rollout of the pilot within the respective site. For example, working groups provided information on communication methods used within each pilot site, timing of data collection activities, and recruitment for data collection activities. The working groups were also responsible for the development and implementation of the site-level action plan.

Phases

The pilot began in April 2019 and ended in September 2022, after receiving a 6-month extension due to COVID-19. It followed six key phases as outlined in Figure 5. An interim evaluation was conducted during Phase 4.

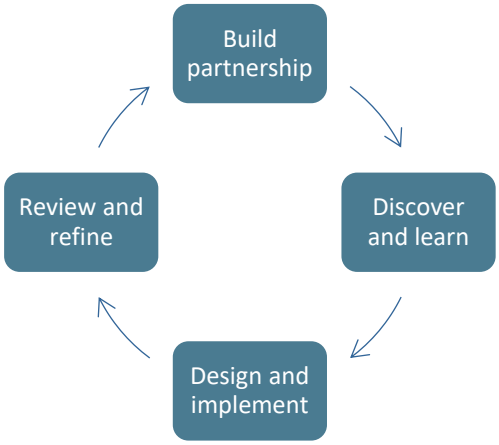
Fig 5. Pilot Phases



Approach

The pilot took an action research approach where the rollout of the pilot (action) was accompanied by evaluation activities (research). Such an approach generally follows a continuous cycle of evaluation and improvement, as seen in Figure 6. In line with this approach, the CPSU project team, ISCRR evaluation team, and pilot sites worked collaboratively to revise pilot processes and the toolkit design as the pilot progressed.

Fig 6. The cycle of action research approach



The reasons for using this approach were threefold:

- It encouraged sites to take a localised and responsive approach to implementation. This was in line with the context-specific approach the action planning process aims to achieve.
- The approach was underpinned by the MHIF funding principles.
- It increased engagement, capacity building, and sustainability, improving the impact of the action planning process and pilot.

Where possible, the project team applied a codesign approach with working groups and frontline staff when adapting the contents or design of the toolkit as a result of evaluation findings.

EVALUATION AIM AND METHODOLOGY

Aim

The evaluation aimed to investigate the effectiveness of the toolkit website and its core components: the action planning process, vicarious trauma resources and prevention strategies. Key evaluation questions, seen in the Table 1 guided the evaluation.

Table 2. Key evaluation questions

Theme	Key evaluation questions
Toolkit website	• Is the website useable and effective? • Does the content on the website address an identified need?
Action planning process	• How well did the process detailed in the VTT work in the VPS context? • How could it be improved? • What were the unintended consequences?
Vicarious trauma resources	• What vicarious trauma information and resources are needed? • What resources are effective in the VPS context?
Prevention strategies	• What prevention strategies would pilot site staff like implemented? • What strategies effectively prevent vicarious trauma in pilot sites?

Methodology

The evaluation used a mixed-methods approach; observations and reflections from the project and evaluation team were combined with formal data collection process methods:

- A policy audit
- VT-ORG survey
- Interviews
- Focus groups
- Working group minutes and feedback
- Action plan analysis
- Website analytics

Each of these sources is described in detail below.

Policy Audit

A policy audit was conducted during the design phase of the pilot to investigate whether VGDs had existing policies, procedures, or practices that were trauma related. The purpose of the policy audit was first to understand the current approach to preventing vicarious trauma within VPS, and secondly, to adopt some policies as toolkit resources. CPSU put out a request to VGDs to submit any vicarious trauma-related policies, practices, and initiatives for the evaluation team to review. While a variety of documents were provided, some documents were not included in the audit as they were

not embedded in policy or practice (e.g. research papers the department had contributed to). A total of 50 documents were audited. It is important to note, given the array of documents provided, that it was difficult to assess the evidence base and practical value of the policies via one specific appraisal method. Policies were therefore subjectively judged on whether they fell into the primary, secondary, or tertiary intervention categories.

VT-ORG survey

The VT-ORG is a validated and reliable survey designed to assess organisational capacity, priorities, and needs to address employees' work-related exposure to secondary traumatic content.[8] All staff working at each pilot site were invited via email to complete the VT-ORG online.

Interviews

Semi-structured interviews were conducted with up to three management representatives at each site. Interview participants were purposefully selected based on the relevance of their role to the project. Interviews took approximately 30 minutes and were guided by a question schedule that focused on knowledge and awareness of vicarious trauma and organisational strategies to prevent vicarious trauma.

Focus Groups

Client-facing staff were invited to participate in a site-specific focus group. The discussion was guided by an interview schedule that focused on knowledge and awareness of vicarious trauma and organisational strategies to prevent vicarious trauma. Focus groups varied in number and size depending on the number and availability of staff at the site. Each focus group discussion lasted approximately 1.5 hours.

Survey, interview and focus group data collection

Survey, interview, and focus group data were collected at two time points: baseline and follow-up. The follow-up data collection phase was not completed in three sites as a vicarious trauma action plan was not implemented as intended (see findings for more information) or staffing shortages due to the COVID-19 pandemic limited the availability of staff to participate. The total response rate for the VT-ORG, interviews, and focus groups can be seen in Table 3.

Table 3. Response rate by site

	Baseline			Follow up		
Site	VT-ORG	Interview	Focus group	VT-ORG	Interview	Focus group
A	26	2	5	24	1	5
B	46	3	5	14	2	5
C	46	2	14*	0	0	0
D	11	2	7	0	0	0
E	21	1	4	14	2	0
F	19	2	5	0	0	0

*includes focus groups with supervisors and managers

Working Groups

Working groups began meeting during the engagement phase of the pilot (Phase 2); they continued to meet monthly until the pilot was completed (Phase 6). The progress of the working groups was monitored by the project and evaluation team. Working group meetings were also an opportunity for working group members to provide feedback on how the action planning process could be modified and the toolkit design. This feedback formed a part of the action research cycle.

Action plan analysis

Action plans developed by each pilot site were analysed during the final evaluation to determine whether the action planning process was effective and what prevention strategies could be effective in the VPS context. The analysis examined:

- Number of actions identified
- Number of actions implemented
- Whether actions targeted organisation-level strategies
- Whether the actions aligned with research or best practice prevention
- Whether actions addressed a gap identified by the pilot

Website analytics

Website analytics were collected regularly by CPSU following the rollout of the toolkit. Analytics were collected to inform the number of toolkit users and how the website was being used.

Findings

Findings discussed in the next section are drawn from the above outlined data sources. Where possible, findings have been appended with considerations to support future prevention efforts. The first section addresses the usability and appropriateness of the toolkit. The second section examines the action planning process piloted, including the working group model. The third and final section describes the vicarious trauma prevention strategies implemented and the evidence supporting their use; strategies for further research are also proposed.

1. USABILITY AND EFFECTIVENESS OF THE WEBSITE

As a key deliverable of the pilot, the design, implementation, and testing of the website is a core component of the pilot and evaluation. Whether it is useable and effective in preventing vicarious trauma, and whether the toolkit addresses an identified need or at-risk population, is explored below.

Is the website usable and effective?

Early testing of the website by the project team and working groups indicated the VTT model and resources were not appropriate for the VPS audience. This was predominately because:

- Resources included in the VTT were largely academic and behind a paywall, limiting access and useability for VPS staff
- The VTT was largely targeted to first responder organisations accordingly the majority of the resources were not relevant to pilot sites
- Pilot sites did not have fundamental knowledge of vicarious trauma and organisation level prevention to design or implement an action plan; education, training, and support were required beyond what was available in the VTT
- Resources were not applicable, transferable and/or consistent with the VPS context and policy, hindering VPS staff engagement

Website analytics verified the lack of suitability. For example, the website included a series of steps users were expected to progress through to design and implement an action plan (similar to the process described by the VTT in Figure 1). However, analytics from August 2020 to November 2020 showed approximately two-thirds of the 153 toolkit visitors left the site from the landing page without further interaction. This data suggests users were not engaging with the website as anticipated and the array of resources included on the website were not being accessed.

To address useability issues, the project team worked to redesign the website. The redesign began in mid-2021 and the final toolkit was launched in September 2022 after pilot sites had ceased participating in the pilot. The redesign work is informed by:

- Findings from a recent evidence review on prevention and intervention strategies for cumulative trauma[2]
- The policy audit
- Grey literature scan of comparable toolkits
- Lived experience data collected from frontline staff and management
- Feedback from stakeholders (working groups and Steering Committee representatives)
- VT-ORG survey results
- Subject matter experts on the project team

Given the website redesign was not completed prior to the final evaluation being conducted, evaluations of its effectiveness or usability are not in the scope of this report. Findings from the broader evaluation, including the action planning process implemented by pilot sites, the vicarious trauma resources developed and the prevention strategies proposed and piloted, provide insights into the effectiveness of the redesigned website and its potential uses. Whether the website targets an identified need has also been determined and is discussed below.

The website was not used as intended so a redesign process took place. The redesign was completed after the evaluation took place. Evaluations of the website's useability and effectiveness to prevent vicarious trauma are out of scope.

Toolkit appropriateness

The WorkWell MHIF targets Victorian workers identified at the greatest risk of mental injury, including frontline service providers. Accordingly, pilot sites were selected based on the high number of client-facing services provided. Due to the absence of site-level data on mental health claims or rates of exposure, the level of risk to pilot site employees was assumed based on trauma theory. Additionally, at the time of site selection, little was known about the vicarious trauma prevention strategies or policies currently in place.

Does the website target vulnerable workers?

Data from the baseline consultation showed the website successfully targeted vulnerable workers. For example, participants reported exposure to traumatic content as a frequent and inherent part of their role. The content was described as '*explicit', 'upsetting', 'graphic', 'really heavy',* and happening '*every day*'. It also came in varying forms, such as: reading case notes, viewing images, outreach work, or face-to-face disclosures. In line with the definition of vicarious trauma, participants described repeated exposure to have a delayed or cumulative effect with impacts varying according to the individual, role, and services provided. Table 2 shows the varying impacts regular exposure to traumatic content had on focus group participants and their colleagues.

Table 4. Impacts of exposure to traumatic content described by focus group participants

Theme	Quote
Mental health	*"I actually developed anxiety that I take medication for since working for the department, so it's not something that's discussed."* *"And I know that it was myself and a couple of other staff who also found that they developed anxiety, and we approached a manager and spoke about it, and they were really shocked…"* – Focus group 3, participant 2
Physical health	*"…And sometimes something will rattle me. Someone will tell me something and it'll just send me into like I've almost got a heart attack…"* – Focus group 3, participant 4
Relationships	*"And we hurt. We're normal people and we're not supposed to take on these things. We're not supposed to take on things in that backpack, but it gets so heavy. You know, that backpack just keeps filling up and then eventually we get home or we come from the home office here into the bedroom and we don't want to speak to our family because we're so, you know, nothing."* – Focus group 3, participant 3
Staff turnover	*"It's just downright trauma, and this colleague that experienced a trauma went on workers comp… And yeah, [they] did try coming back for a while, this co-worker… [they] obviously experienced a trauma that [they] couldn't work with us anymore."* – Focus group 3, participant 4

Theme	*Quote*
Avoidance	*"I know when it's anxiety because I can feel it coming from the ground up. And then I just want to shut the computer and not do anything for a couple of days, but you can't do that because you can't take leave without permission…"* – Focus group 3, participant 4
Lack of services/resources	*"…that's what hurts, I think, everybody because we all want to help our clients but sometimes you've got to shut your eyes to things. And that's not what our job is supposed to be. We're supposed to be able to link these people and go on with our business, but there's no-one to link them and then that's where we take on their traumas and then we bring it home and then we start to get a bit reserved."* *"I would love to just be able to provide the assistance to our clients. I want all my clients to thrive, but we just don't have the time"* – Focus group 3, participant 4
Productivity	*"[If some of these issues are addressed] I think that we would see increased productivity. We talk about all the things that we would see – that people are happy to come to work, people are excited about what they do."* – Focus group 3, participant 2
Workplace culture	*"But it's not discussed. It's not something that I feel can be openly discussed in our workplace either, without fear of repercussions, and there's a bad culture that comes from above, that if you speak up about something, you're a bit of a problem or a loudmouth or a troublemaker, and it stops people from bringing that up freely."* – Focus group 3, participant 2
Job satisfaction	*"And I know that the satisfaction I get from getting a client through helping them doing whatever is immense, but the pressure is where the hate comes in because we can't give those clients the service that they deserve. Yeah, and the pressure's huge. It's huge. I think it makes us sick at times."* – Focus group 3, participant 3

What vicarious trauma policies are currently in place?

The policy audit identified a potential policy gap in the VPS regarding the prevention of vicarious trauma in this sector. Findings from the audit showed the vast majority of the policies were reactive and aligned with tertiary or individual level responses, with no policies taking a primary prevention approach. Few policies specifically addressed vicarious trauma.

By targeting VPS staff and primary prevention of vicarious trauma the website is addressing an identified need.

Considerations

- Given the level of risk and lack of primary prevention initiatives identified in the pilot sites, it is important to establish and implement effective organisation-level prevention strategies to protect staff exposed to trauma content from mental injury.
- Organisations need to collect qualitative to accurately determine risk and impacts associated with exposure to traumatic content.
- Further research will need to be conducted to ascertain whether the redesigned website is useable and contributes to the prevention of vicarious trauma.

2. EFFECTIVENESS OF THE ACTION PLANNING PROCESS

The action planning process outlined in the VTT (see Figure 1) was drawn on to support each pilot site to develop a context-specific response to vicarious trauma. It was planned that pilot sites would draw on a series of steps outline on the toolkit website to self-direct through this process. However, due to the limitations of the website and redesign process (see Section 1. The usability and effectiveness of the website), pilot sites were guided through the action planning process by the project team. While this had limitations for evaluating the usability of the website as a stand-alone resource, it allowed the four steps underlying the action planning process to be piloted in the VPS context. A summary of each step and any underlying tasks are summarised below. Learnings from the implementation of the action planning process are provided for each step, this includes:

- A description of how this step was applied in pilot sites
- Strengths of the process when applied in the VPS context
- Limitations of the process when applied in the VPS context
- Considerations for future use

Step 1: Lay the foundation for success

The VTT describes Step 1 as:

"Obtain the commitment and support of your organization's leadership to embark upon this process and have them designate an individual or team to coordinate and guide the effort."[7]

It includes three tasks:

1. Obtain commitment to establishing an organisational response
2. Designate an individual or team to coordinate and guide the effort
3. Encourage open communication with staff

Application in pilot sites

The project team met with management at each pilot site to explain the pilot aims and processes and to secure support and commitment. The project team then presented to staff at each site to introduce the pilot, the project team, and the topic of vicarious trauma. To form a site-specific working group to drive the action planning process, relevant management representatives were identified by the project team and an expression of interest invitation was emailed to all staff. Given pilot sites varied in size, structure, and service provision, working groups were encouraged to reflect on whether the group could effectively represent staff and have decision-making capacity. Working groups aimed to meet monthly throughout the life of the pilot.

Strengths

Inclusion of frontline staff with lived experience

As a hazard that impacts frontline staff, their inclusion in the implementation of action planning process and the website redesign ensured lived experience was considered.

> *It was also good to have staff to have a voice and to step out of their usual role and look at how they can contribute to the health and safety and wellbeing of themselves and their colleagues.*
> *– Interview participant 4*

Flexible implementation

The project team and pilot sites adapted the action planning process to meet the varying needs of each pilot site. For example, the presentations to staff on the topic of vicarious trauma revealed differing levels of knowledge and awareness. For some staff, this was the first time they had heard of

vicarious trauma. One pilot site requested the project team present to staff a second time after questions arose following the first presentation. The project team also adapted the training materials developed as part of the pilot to cater to this variability in knowledge.

Framing exposure to traumatic content as a hazard

Exposure to traumatic content was not widely acknowledged as a workplace hazard. As a result, there was confusion among stakeholders on the meaning of key concepts (vicarious trauma and organisation-level prevention) and the need for the project. Framing exposure to traumatic content as a hazard and vicarious trauma as a workplace injury helped pilot sites to understand the importance of preventing vicarious trauma and the organisation's obligations in doing so.

> *"It's good to identify risk to our staff and to practice steps to mitigate those risks. It's a good acknowledgement of the challenges that staff face and it's something that we've learnt a lot from, the process, about the risk and it also makes focus on our broader systems for reporting risk and we've identified some deficits in a number of areas which extended from the project." – Interview participant 4*

Limitations

Balanced representation on working groups

Working groups required balanced representation to be effective. Ideally, this would have consisted of representatives with decision-making capacity, Occupational Health and Safety (OH&S) knowledge, lived experience of exposure to traumatic content, and representation from all affected business units and services. This was not possible or feasible in most sites due to the size of the site, workload or lack of staff.

Similarly, pilot sites are a part of a broader department, and the VPS, accordingly, are not fully autonomous. Despite this, representation on the working group from leadership external to the site was not sought during the EOI (neither by the pilot site or the project team). As a result, knowledge and change regarding vicarious trauma achieved during the pilot remained largely within the pilot sites.

> *I still think it was predominantly CCS-led, and for a lot of the tasks on there, they may not have got finished if we didn't have the [one] Team driving it…I liked the idea of it being multi-business unit, because it's not just [one] that's impacted by vicarious trauma. But I don't know that we did a good job at an equitable split…* – Interview participant 2

Inconsistent attendance at working groups and high membership turnover

Workload, staff turnover, and the impacts of the COVID-19 pandemic hindered regular and consistent participation in some working groups. This resulted in knowledge loss and delayed progress. A reactive work environment in select sites also contributed to staff not being able to attend meetings regularly.

> *I think the unsuccessful part was we did have to reschedule a number of times, because – and some of those were just clashes, and because central would put things in over the top at last minute… We had a number of staff absences. We had the inability to get more staff involved and [I] reflect upon perhaps how we could've driven that more.*
> – Interview participant 4

Workplace culture impacted on the functioning of working groups

While some working groups functioned effectively, some frontline staff reported workplace culture hindered their capacity to participate in the working group. A lack of psychological safety, a reactive work environment, stigma around vicarious trauma, inconsistent working group leadership and an emphasis on the need to be resilient resulted in frontline staff not contributing actively during working group meetings.

Success relied on site champions or active support from management

Workload and the impacts of COVID-19 limited the working group members' capacity to take responsibility for implementing the action planning process.

Pilot sites that successfully adopted the action planning process and implemented action plans that targeted organisation-level prevention commonly had a champion or management representative that led the effort. This resulted in an increased workload for these individuals that, at times, became onerous.

> *I would have been able to engage in this process more meaningfully and maybe have enjoyed the process a bit more if I hadn't had to take some lead on so many things.*
> – Interview participant 3

! Working groups were not an effective mode for driving the action planning process in pilot sites.

Considerations

- Given the numerous limitations identified, the working group model, as adopted, is not an appropriate format for driving the action planning in pilot sites. Further research is needed to develop an approach that balances the strengths and limitations identified, including one that:
  - targets organisational level prevention
  - has equal representation with balancing of department staff
  - is informed by lived experience and mixed methods data
  - is adequately resourced
  - ensures participating staff are upskilled via introductory training
  - facilitates contribution from subject matter experts
  - can be sustainably and flexibly implemented, and
  - ensures department-wide accountability
- Key stakeholders to be provided training on vicarious trauma and exposure to traumatic content as a hazard prior to implementing the action planning process.
- Consider creating positions (at the site, department and/or organisation level) that includes a vicarious trauma champion and related activities in the position description and

Step 2: Assess organisational capacity for addressing vicarious trauma

The VTT describes Step 2 as:

"Use the VT–ORG to conduct an evidence-informed assessment of your organization's current capacity as a vicarious trauma-informed organization."[7]

It includes four tasks:

1. Create a realistic timeline for data collection
2. Conduct the VT-ORG assessment
3. Determine current capacity as a vicarious trauma-informed organisation
4. Prepare a report to share with VT-ORG assessment findings

Application in pilot sites

As a part of the baseline data collection, the VT-ORG survey was rolled out in pilot sites. To facilitate a deeper understanding of each site's current capacity to prevent vicarious trauma, the evaluation team conducted interviews with management and focus groups with frontline staff (see Methods section for more information). To maximise participation in data collection activities, working groups advised the project team on engagement strategies and promoted the project among colleagues. Data collection activities were timed not to coincide with other data collection activities or peak workload periods in each site.

The evaluation team provided each pilot site with a summary of survey results and a report based on focus group and interview findings. The reports included information on vicarious trauma risks to staff, current strengths and weaknesses of the pilot site and potential prevention strategies for implementation. These summaries formed the baseline data from which action plans were designed.

Strengths

Inclusion of qualitative data

The addition of qualitative data in the baseline data collection proved invaluable. The project team and pilot sites relied heavily on qualitative data to inform the action plans and the design of the toolkit. In some instances, findings from the interviews and survey were contradictory, which provided an impetus for further discussion.

The collection of these data further shed light on the limitations of relying on quantitative data to determine vicarious trauma risks. Focus group participants explained that the latent effect of exposure to traumatic content combined with the level of exposure in some roles and services makes reporting vicarious trauma-related hazards and impacts difficult. In fact, despite the high rate of exposure and impacts reported, no focus group participants had reported exposure to traumatic content either as a hazard or incident via their organisation's health and safety reporting system. As a result, quantitative data on exposure to traumatic content and its impacts on staff is likely to be highly unreliable. The findings on the impacts of exposure to traumatic content discussed in the previous chapter are an example of how qualitative data plays a crucial role in understanding vicarious trauma risks and impacts.

Limitations

VT-ORG survey results were similar across sites

VT-ORG results followed a similar pattern across sites. As a result, pilot sites had similar priority areas for action recorded in their action plan. This suggests the VT-ORG may not be useful in identifying site-level capacity to address vicarious trauma and that the priorities identified are relevant department-wide, or perhaps VPS-wide. One pilot site drew on the VT-ORG as a checklist and cross-referenced the survey findings with the qualitative report to develop their action plan.

Survey fatigue among staff resulted in a recommendation that follow-up survey not be rolled out in some sites and a lower response rate was recorded at pilot sites that did roll the survey out. The total number of VT-ORG responses reduced from 169 for the baseline data collection to 52 for the follow up data collection. To overcome the challenges associated with survey fatigue, the checklist approach used by one site may be an alternative method of collecting data to support action planning.

Role of evaluation team

The evaluation team was responsible for collecting, collating and reporting data. It is unknown whether pilot sites have the capacity or capability to conduct such activities without the use of pilot resources. The use of the evaluation team to collect data also provided participants with confidentiality, this may be harder to guarantee if the organisation was directly responsible for collecting data from employees, and may change what employees are comfortable to report.

Considerations

- Redesign website to include recommendations and information to promote the collection of qualitative data.
- Modification of the VT-ORG survey to be used as a vicarious trauma prevention audit. Each survey question could be scored by an OHS or management representative based on the current prevention activities. The results of the audit could then be translated into a vicarious trauma action plan. This could be complemented by follow-up data collection using the VT-ORG as a survey combined with qualitative methods to assess effectiveness of the action plan over time.

Step 3: Determine priorities and develop an action plan

The VTT describes Step 3 as:

"Discuss the VT–ORG findings within each of the five areas of organizational health and identify priorities and a timeline for addressing them. Create a realistic action plan that identifies specific tasks, persons responsible for those tasks, timeframes for completion, and a process for monitoring progress, which may include re-administering the VT–ORG to assess improvements."[7]

It includes four steps:

1. Identify areas of strength and gaps
2. Review the VT-ORG assessment findings
3. Create an action plan
4. Share the action plan with staff
5. Evaluate organisational response

Application in pilot sites

Working groups met monthly to discuss baseline data and determine priority areas for action based on findings included in the report and VT-ORG results. Some pilot sites undertook additional consultation with staff to gain further insight into specific baseline findings.

Strengths

Use of subject matter experts

Subject matter experts on the project team played a critical role in facilitating discussions in working groups and directing working groups through the action planning process. Several of the outcomes achieved by the pilot sites are due to the support of subject matter experts rather than website resources or processes.

Subject matter experts played a crucial role in facilitating the action planning process indicating the website may require expert facilitation or support outside of the pilot.

Limitations

Lack of understanding of vicarious trauma

Focus group and interview participants reported varying levels of training and understanding of vicarious trauma. Almost all training was reported to focus on individual prevention or resilience-building practices. As a result, there was a lack of understanding across all pilot sites as to what vicarious trauma is, how it manifests and how it can be prevented.

In addition, participants and working groups tended to conflate vicarious trauma with critical incidents. Accordingly, exposure to secondary trauma material and its cumulative effects was easily overlooked by participants, working groups, and the organisation; instead the causes, consequences, and organisational responses to work-related violence took priority.

Time intensive

The action planning process was far more time intensive than expected. This was commonly due to:

- Pilots did not receive any additional resourcing to participate in the pilot despite participation increasing workloads. This limited the ability of working group members to take on the responsibilities associated with action planning or the broader pilot
- Significant time was needed to train and educate working group members on vicarious trauma and organisation-level prevention
- VPS decision-making processes were complex and time intensive and pilot sites did not always have the remit to implement actions
- Funding was not allocated for the implementation of actions. Additional time was required to secure funding to implement some action plans

These time delays impacted negatively on working group engagement, action plan implementation, project resourcing, and the evaluation.

> *At times, it felt quite slow in pace. And look, some of that is public service – Like, trying to get that funding for the outside supervision sessions felt like it took bloody forever. And so, that was a challenge sometimes, the pace of how slowly it felt like things were moving.*
> – Interview participant 2

Considerations

- The use of the redesigned toolkit by VPS department and sites could be supported or facilitated by vicarious trauma subject matter experts.
- Department wide training on vicarious trauma is required to ensure all staff understand the risk of exposure to traumatic content, the organisations responsibilities to protect staff and the individual and organisation-level prevention strategies that are available.

Step 4: Explore toolkit for resources to implement your action plan

The VTT describes Step 4 as:

"Use the priorities and tasks in your action plan to guide your navigation and exploration of the VTT. Gather research, policies, practices, programs, tools, and other resources, including those created expressly for the VTT, to support your organisational efforts to address the needs of your staff."[7]

There are no underlying tasks listed under Step 4, rather the VTT has tips included on how to explore the VTT repository.

Application in pilot sites

In place of a website, subject matter experts from the project team supported pilot sites to develop strategies to implement as a part of their action plan. Strategies were designed in accordance with evidence from the literature, baseline data (survey, focus group and interview results) and feedback from working groups. Each working group was encouraged to implement strategies that best aligned with the findings for their site and to tailor the implementation of the strategies according the unique characteristics of their site.

The strengths, limitations and considerations pertaining to Step 4 of the action planning process cannot be determined by the evaluation as the information was provided to working groups by the project team rather than the toolkit.

3. VICARIOUS TRAUMA KNOWLEDGE AND RESOURCES

The pilot aimed to research and develop a suite of vicarious trauma training resources for inclusion in the website. In order to tailor the resources of the VPS audience, the pilot first sought to understand the vicarious trauma training needs of pilot site staff. This section summarises the level of vicarious trauma knowledge and awareness among pilot staff and the effectiveness of training materials developed and tested during the pilot. As the toolkit was not completed prior to the evaluation the content on the website is out of scope of the evaluation.

Vicarious trauma knowledge and awareness

Baseline data showed the majority of participants did not understand the cumulative risks associated with repeated exposure to traumatic content. Participants could largely define what vicarious trauma was; however, the majority reported that the broad definition was the extent of their knowledge. Several participants indicated that the information presented as a part of the pilot rollout was their first introduction to the topic. Participants from both departments reported there was no consistent or comprehensive source of information on vicarious trauma and that most training provided by their respective departments had focused on individual-level wellbeing strategies such as resilience training that were not effective in the face of workplace stress or the level of trauma material they were engaging with.

> *Some people get frustrated on, "Why did something so small, affect them so much?" So if they understood that because that's happened to you six times now, I think it would be good to label it… Because we do, we look at each incident individually, but we don't look at it as a collection.* – Interview participant 4

The pilot sites, departments and the organisation tended to use clinical language when referring to vicarious trauma. The project team found this language encouraged staff to attend to the personal impacts of their work only when they notice symptoms associated with vicarious trauma. For example, consultation participants repeatedly requested for further information and training on how to identify vicarious trauma with particular emphasis on symptoms. Similarly, in the early stages of action planning with working groups, the project team observed a tendency for the group to revert to discussions on symptomology and clinical interventions that focus on the individual treatment of vicarious trauma. Whilst knowledge of vicarious trauma symptoms and its treatment or management play an important role in reducing the negative impacts of vicarious trauma, it does not replace the need for proactive prevention of vicarious trauma hazards.

Additional training requests included an embedded approach that is applied site-wide. Training for supervisors and management was also described as key to such an approach given their leading role in facilitating discussion around prevention and impact, and embedding prevention approaches into practice.

!	Pilot site staff were found to have mixed levels of vicarious trauma knowledge and awareness, and the training provided focused on individual-level symptoms and supports.

Vicarious trauma training framework

To develop a training framework, the project team undertook a co-design process with the DJCS Learning and Development team and a pilot site. The framework aimed to provide participants with an applied understanding of vicarious trauma and frame exposure to traumatic content as a workplace hazard requiring multiple levels of prevention.

The training was piloted with three teams in three pilot sites between July 2021 and May 2022. The training was scheduled to run between two and three hours depending on the availability of staff. Due to the COVID-19 pandemic, all sessions were delivered online; between two and six staff were in attendance. Participants in two sessions included teams based at the same location that worked together and were familiar with each other; one session included staff from different pilot sites who were unfamiliar with each other. Facilitators from the project team had a background in social work, and were subject matter experts on vicarious trauma.

The training covered three key areas:

- What is vicarious trauma?
- What contributes to vicarious trauma?
- What can I do about it? (for frontline staff) or vicarious trauma and OHS (for Health and Safety Officers)

The delivery of the training aimed to be flexible, responsive and inclusive. Each training session was tailored to the work context of participants. For example in the first iteration of the training (in July 2021), a vicarious trauma case study was developed based on the roles and responsibilities of training participants. This was used to prompt discussion and increase the relevance of the training content. In addition, open-questions and activities enabled facilitators to informally gauge vicarious trauma knowledge, awareness, and attitudes. Delivery of the following activities and discussions was then tailored accordingly. Each training session was modified and updated based on learnings from previous sessions.

Effectiveness of the training

As the evaluation of individual training session was out of scope of the evaluation, data collected by the DJCS Learning and Development team following the first training session was drawn on to investigate the effectiveness of the training. Four out of six participants completed the survey. Survey data showed:

- Three out of four respondents reported increased knowledge and ability to demonstrate the majority of learning objectives
- All respondents agreed they would use what they learned immediately and into the future
- All respondents agreed the facilitators were engaging
- All respondents agreed they would recommend the program to co-workers
- All respondents indicated they were confident and committed to applying what they had learned back on the job

When asked how the training could be improved all participants agreed that given the importance of mental health in the workplace, more time needed to be allocated to training and education on vicarious trauma. It was suggested a full day be allocated to vicarious trauma annually.

> *Given the nature of the topic and the need to discuss some aspects in depth so everyone has a clear understanding, I think that the program should be longer. A full day so that everyone involved has more time to discuss examples and provide clarity.*
> – Survey participant 4

Participants in the final two training sessions were invited to submit feedback to the evaluation team. Submissions identified the key strengths of the training to be:

- The skills of the facilitator
- The conversational and inclusive format
- The tailored approach

The day we spoke with [the facilitator] as a team, I think was very positive outcome as everyone had a chance to speak about personal experiences and had [the facilitator] as a great sounding board. We all spoke after the meeting finished all of us enjoyed and felt that it was well presented… – Training participant 1

Vicarious trauma training that is tailored to the work context, allows adequate time and takes an inclusive approach is likely to be most effective.

Considerations

- VPS develops a comprehensive vicarious trauma prevention framework that promotes a shared understanding vicarious trauma as an OHS risk.
- Training on vicarious trauma is needed for staff involved in the provision of frontline services, both directly and indirectly. To be successful, the training needs to include a shift in focus from individual-level to organisation-level prevention and frame vicarious trauma as an occupational health and safety concern.
- Staff involved in the action planning process may require additional training on vicarious trauma to support their role in implementing prevention strategies.
- Learnings from the training pilot can contribute to the development of a training framework that can be reliably implemented and tested.
- Organisations collaborate with tertiary and training institutions to ensure that qualifications that lead to front line service delivery include vicarious trauma education that frames vicarious trauma as a workplace hazard.

VICARIOUS TRAUMA PREVENTION STRATEGIES

As a part of Step 3 of the action planning process, working groups across the six pilot sites reviewed the findings from the survey, focus group and interview participants to determine priority areas for action. Numerous vicarious trauma prevention strategies were identified as a part of this process and a number of strategies went on to be implemented via pilot site action plans. Evaluating the effectiveness of each strategy implemented was out of scope of the evaluation, however where relevant, data monitoring their implementation and effectiveness has been collated. A number of strategies that were proposed by participants or working groups could not be implemented during the pilot due to an array of constraints (e.g. budget, timelines, COVID-19, etc). As a result, there is no pilot data available on whether they contribute to the prevention of vicarious trauma. This section summarises strategies that were identified and/or implemented. Prevention strategies have been divided into two tiers:

- Prevention strategies with pilot data supporting their implementation or effectiveness
  - Reflective practice
  - Formalising vicarious trauma discussion
  - Regular wellbeing forums
  - Psychological Wellbeing Service
- Prevention strategies with no pilot data to support their implementation or effectiveness
  - Increase the availability of vicarious trauma resources
  - Organisation-level wellbeing Key Performance Indicators
  - Data collection on exposure to traumatic content
  - Vicarious trauma risk assessment by role
  - Vicarious trauma activities sheets
  - Family support forum
  - Content warnings
  - Review sources of preventable exposure

Due to the limited amount of data collected on specific prevention strategies, both tiers of strategies require further work to establish the extent to which they are effective in preventing vicarious trauma and implemented by organisations.

Strategies with evidence of effectiveness

Data from follow-up focus groups, interviews, and the VT-ORG survey combined with feedback from working group members provided early evidence of effectiveness for a number of prevention strategies implemented by pilot sites. Information on the implementation, effectiveness, and impact of these strategies is provided below.

Reflective practice

Reflective practice, or critical reflection, refers to the purposeful examination of the assumptions underpinning human experiences and practice, with the goal of improving the way people work, understand themselves, and relate to others. It is both a theory and process that can be utilised and implemented in a variety of ways.[10] Historically, the emphasis has been on individual reflective abilities or how reflective practice can supplement the support function of supervision. More recently, there is growing interest in peer models and how to create critically reflective organisations or cultures.[10]

Focus group participants highlighted a significant gap between the support provided via regular supervision and other available supports, commonly Employee Assistance Program (EAP) or critical

incident debriefing. Participants explained supervision practices tended to prioritise performance management, which did not complement discussions of wellbeing. The ability of supervisors to effectively address wellbeing varied depending on the skills of the supervisor. EAP and debriefing did not play a role in preventing vicarious trauma, as they were generally implemented in response to a specific incident or once an individual was experiencing distress. This gap was common across all pilot sites. Given vicarious trauma risks are inherent in the work and cumulative, participants highlighted the need for supports that:

- Consider the work context
- Could be embedded in practice
- Promoted collective care

> *This is something that as a department, we do pretty poorly. Yeah, we have supervision sessions and stuff but a lot of the time, that's not actually focused on staff wellbeing and issues.* – Focus group 1, participant 4

Action plan analysis showed all six pilot sites selected reflective practice as a strategy to address this gap. Three pilot sites implemented reflective practice sessions during the course of the pilot, to varying degrees of success. From the remaining three sites, reflective practice remained a pending action on their action plan.

Format

Pilot sites took differing approaches to the implementation of the reflective practice (see Table 4).

Table 5. Reflective practice format

	Site A	Site B	Site E
Facilitation	External facilitator	Internal facilitator upskilled	External facilitator
Participants	Open to all staff	Open to all staff	Closed group
Frequency	12 x monthly sessions	Irregular sessions	6 x monthly sessions
Status	In progress	2 session implemented	Completed

The model used at Site B and E involved a participant volunteering to present to the group about an incident or *'things that have stayed with them'.* The group then unpacked this incident following a series of outlined steps to understand the presenter's underlying assumptions and dynamics. Due to the COVID-19 pandemic, sessions were delivered virtually and face-to-face.

Barriers

Pilot sites were not resourced by the pilot to implement reflective practice; sites either sourced funding to implement externally facilitated reflective practice or upskilled staff with prior experience in reflective practice to implement internally facilitated sessions. Securing funding was the main reason reflective practice was not implemented at all pilot sites.

For the sites that did implement reflective practice sessions, securing staff commitment to participate was a significant challenge. Two pilot sites had low and irregular attendance. This was commonly attributed to workload, lack of commitment from the organisation, uncertainty around process and benefits, and workplace culture.

I think when it initially came out, I was interested because I think mental health and everything is super important, and then I think I got really worried that it would take up a lot of my time, because there's a lot of stuff to do at work. – Focus group 1, participant 2

So we've had those sessions, which have been a drain in terms of time. I enjoy them when I'm there, but the stress I get around those appointments, because it's an hour every three or four weeks. And I really enjoy them when I'm there, but it's the resources and it's the time. We don't have time for it at the moment, and that's just a whole bigger staffing issue. But what I'm saying is they're great when we can do them. – Focus group 2, participant 2

In the back of my mind, it was the hope that it wasn't just another thing that will start and then just die off, hope that it is something that can continue…
– Focus group 1, participant 1

I just thought it could go two ways. It could be where no one talks about anything and it's very superficial or it could be very beneficial for people, so after the first session, I thought, 'This actually could work and would be quite helpful to unpack things in a different way.'
– Focus group 1, participant 5

…that notion that there are lots of people here we could invite in, but they'd completely stuff it up. They'd want to be solution-focused… they wouldn't be able to maintain confidentiality. We couldn't trust them. – Interview participant 1

Success factors

One site overcame engagement barriers by strategically selecting staff members to participate in reflective practice sessions facilitated by an external provider. The selection process ensured participants had diverse levels of experience and a demonstrated commitment to wellbeing. The dynamic of the group was also considered.

We're going to be really cautious about who gets to be part of this…
– Interview participant 1

We wanted to select people that we knew would give the group a good, hot crack rather than use the sessions to just pay out on the business and what goes on.
– Focus group 1, participant 4

This selection process proved to be an effective strategy; a cohesive group was formed, sessions were consistently attended and all members contributed.

I'll be honest, I was put in it, didn't particularly want to be in it but I guess after that first session, I probably saw the value in it and that's why I stayed.
– Focus group 1, participant 4

The group dynamics, familiar format, and importance placed on psychological safety created a reassuring environment and fostered a sense of trust among the group.

It just seemed like a really trustworthy, honest group, and so it felt really - you felt really included and it did feel like you could just debrief in a different manner, so that's what kept me going I suppose – Focus group 1, participant 2

I go in with cheat sheets, which outlines the steps and the process. So, at any point, anyone can go, "[facilitator], where are we?" and I'll go, "Oh. Sorry. We're at step three."… I take them in every time and distribute them, whether people look at them or not.
– Interview participant 1

Participants commented that management had enquired about the progress of the group and maintained support despite the group requesting the sessions remain confidential. The endorsement and support from management were perceived as supportive and contributed to fostering a sense of trust amongst the group.

Impacts

The impact of participating in reflective practice sessions varied across pilot sites, with consistent and active participation resulting in greater impacts.

Reflective practice was an effective format to debrief for those that attended, with several participants describing a sense of relief after presenting or contributing to the group.

> *Some of the stuff that's heavy may really affect someone so that was something that we were all aware of. There was a lot of tears but you know what? That to me is a good thing. That's a releasing of energy. That's letting stuff go. I think a lot of people felt a sense of relief at the end.*
> - Focus group 1, participant 4

> *I presented in our first session which I guess going into it, I wasn't really sure what to expect and then just presented on the fly but afterwards, I guess felt probably a big weight off my shoulders from the presentation and actually putting things out there for the group.*
> – Focus group 1, participant 3

> *If we can bring this in really effectively, it's going to help with staff retainment. People are going to get burnt out. We're able to talk about these things and it's funny because we always say that we're dealing with humans, humans that have mistakes, all that kind of stuff but we forget that we're humans too and that part is sometimes forgotten by management* – Focus group 1, participant 4

The group format provided the opportunity for participants to discuss shared experiences and develop a shared understanding of the risks inherent in the work. This fostered collective care among the group that could be continued outside the sessions to benefit the broader workplace.

> *I guess as an observer, watching everyone else present over the weeks, we all know that we've been through crap but to actually talk about it and hear other people talk about it is kind of a relief as well, just to know that we're all in similar boats to each other, it's not just us.*
> – Focus group 1, participant 3

> *Some of the topics that we all discussed were quite personal to us and reflected a lot of structure stuff from the business and it was good. I guess watching everyone present gave the group a sense of, "It's not just me."* – Focus group 1, participant 4

> *You don't realise how common the same things will pop up until you do have the discussion. It's hard because a lot of the discussions you have are either very light-hearted or you touched on it and then you've got to go and do something else and you've got the wellbeing stuff which is very individual like, "Here's an umbrella way to deal with it," but to break it down and go, "Okay, this has happened to everyone and this is a common thing that keeps happening. What can we do about it?" and actually change the culture of a business I think is probably the best thing you could get out of it so it doesn't keep happening.* – Focus group 1, participant 5

> *To switch off and think about ourselves and how we're actually feeling and discussing it with people who have gone through similar or other experiences was really beneficial.*
> – Focus group 1, participant 2

Participation in reflective practice supported participants to challenge assumptions that discouraged help seeking and de-stigmatised distress associated with exposure to traumatic content.

> *And then what came out of that was a discussion about what stopped her from asking for support….And it was inevitably, "I don't want to be seen as unhelpful, or needy, or" – and then the group were able to, not so much say, "Oh, me too," but very much, "I remember those days when I felt like that."* – Interview participant 1

So, in a space of 40 minutes, you got a glimpse of what could have been vicarious trauma, and that ability to kind of unpack it very gently as a story, and say, "Next time, put your hand up. Because we all assumed you coped really, really well. – Interview participant 1

Participants highlighted that reflective practice had a focus on unpacking collectively rather than 'fixing' and this distinguished it from other forms of support provided by the department.

The next step about what we would like to see changed might be, but in the moment and the presentation for that particular person, it's their experiences, it's their wording, it's their thing, it's not about fixing it. – Interview participant 1

Reflective practice was found to be an effective vicarious trauma prevention strategy, that promoted a shared understanding of the impacts of the work and reduced stigma surrounding vicarious trauma.

Considerations

- Given the benefits of reflective practice reported by participants, continuation and expansion of the facilitated sessions could be of benefit to all staff. Investigation is needed on how to promote and encourage staff to participate.
- Due to time constraints, the pilot did not collect data on long-term impacts of reflective practice in pilot sites. Further work is needed to determine whether the early impacts are sustained over time.

Formalising vicarious trauma discussion

Focus group participants highlighted the need for vicarious trauma risks to be acknowledged and discussed and for this practice to be embedded and sustained. One pilot site, motivated by the VT-ORG results, successfully implemented multiple actions formalising such discussions. This was predominantly achieved through the inclusion of vicarious trauma questions in recruitment procedures, onboarding, performance reviews and/or supervision, and exit interviews. Examples of the actions implemented can be seen in Table 6.

Table 6. Examples of actions implemented to formalise vicarious trauma discussion

Phase	Prevention strategies example
Recruitment	Unscored interview question included in recruitment procedures: "In the case management of individuals involved in the [service], you will be exposed to triggering written content and engage in sensitive and at times confronting discussions regarding offender criminogenic needs. Over time, these everyday tasks can affect and have an impact on our overall well-being and mental health. What do you think workplaces can do to prevent, reduce or mitigate the impacts of vicarious trauma?"
Onboarding	During orientation of new starters, Managers/Supervisors educate new starters about available support services and local resources. A 'wellbeing pack' containing resources and available supports was also in development.
Performance review/supervision	Staff to develop 'wellbeing plans' that focus on strategies identified by the staff member that support them to acknowledge and process the personal impacts of engaging with traumatic content. Managers/Supervisors to support staff in the development and review of plans.
Exit interview	Introduction of vicarious trauma questions on exit interview survey: • Reflecting on your time within Department, do you think you may have experienced vicarious trauma? • If yes: What changes did you observe in yourself that indicate vicarious trauma? • Were there supports and resources available to you that you utilised/found beneficial when at the location? • What were they? • Which ones did you find the most useful to you? • Were you informed at any time during your employment, either during onboarding or at some later stage, of the psychosocial risks involved when exposed to other people's trauma? • At what point were you informed? • Are there any other resources or initiatives that you think would be beneficial in creating awareness of vicarious trauma at your workplace? • Are there any other supports, resources, or initiatives that you think would be beneficial in preventing vicarious trauma at your workplace?

Effectiveness of formalising discussions on vicarious trauma

A combination of qualitative and quantitative data indicates the actions implemented by this pilot site, aiming to formalise and embed discussions of vicarious trauma, were effective. VT-ORG scores related to the discussion of vicarious trauma prevention strategies during formal employment processes increased from baseline to follow-up. This suggests the actions implemented by the pilot site have increased its capacity to mitigate or prevent vicarious trauma.

Table 7. VT-ORG scores from baseline to follow-up at pilot site A

VT-ORG question	Pre	Post	Change
My performance evaluation includes a discussion of organisational and individual strategies to minimize risk for vicarious traumatization	3.1	3.7	+ 0.6
Meetings with my supervisor provide a forum for addressing exposure to trauma	3.5	3.9	+ 0.4
During the hiring and orientation of new staff, supervisors demonstrate their understanding of the risk for vicarious trauma and the importance of both individual and organisational strategies to address it by asking final job applicants to articulate their own coping strategies	2.9	3.7	+ 0.8
During the hiring and orientation of new staff, supervisors demonstrate their understanding of the risk for vicarious trauma and the importance of both individual and organisational strategies to address it by making final applicants aware of the organisation's strategies to reduce the negative impact of the work	2.9	3.7	+ 0.8

Focus group and interview participants discussed how increased acknowledgement and discussion of vicarious trauma had a normalising and destigmatising effect.

> *It was really good to start seeing questions about VT to new starters, so people being interviewed. So that was great. Because I've never, in the past, never been asked this question before.* – Focus group 2, participant 1

> *Having that focus (on vicarious trauma) really helps to have a focus on… the potential impacts [and] opening up those dialogues and normalising what we can go through each day, day in, day out, for our whole career.*
> – Focus group, participant 3

The introduction of wellbeing plans gave supervisors a framework for discussing vicarious trauma and wellbeing. This translated to increased confidence among staff and in turn increased discussion in supervision and broadly in the workplace.

> *Even the wellbeing plans that we started as part of the VT project helped open up that conversation and perhaps made direct line managers more confident in having those discussions, as well as us.*
> – Focus group 2, participant 2

> *I feel like it's spoken about more. I feel like in formal settings, like supervision, having it known throughout the workplace and the location, and actively doing things, has helped open up the conversation in formal settings, in supervision. Where I think in the past, me, I probably would have been hesitant to discuss it. But even in informal settings, just around the office, if there's a day where something has happened… I'm more open to speaking to someone.* – Focus group 2, participant 2

Considerations

- Given the early indication of good outcomes from formalising discussions on vicarious trauma, the actions and targeted approach documented above could be rolled-out across the department and in other VPS roles with vicarious trauma risks.

Regular wellness forums

One site implemented a group forum where new information on workplace wellness was discussed and promoted each week. The same site also established a weekly forum to facilitate informal debriefing and celebration.

Focus group participants explained these activities helped to reduce stigma around vicarious trauma, increased conversation, and initiated a cultural shift to proactive prevention.

> *I just think it being in the forefront of our minds at the location…in terms of the Wellness Wednesdays and those active initiatives we're taking, has helped open up that conversation and made it less taboo.* – Focus group 2, participant 3

Flexible position descriptions

One site had previously implemented flexible or 'hybrid' positions to allow staff with high levels of exposure to transition to roles and responsibilities with low levels of exposure as required (and where possible). The site had combined two position descriptions, one position known to be high risk for mental injury with another position with less risk but in a related field. This enabled employees to move to the lower risk role as needed or when possible.

> *I think we could to more work around flexible position descriptions, to try and minimise people, or at least have the space to be able to move people around if they are starting to show signs or symptoms of vicarious trauma, or saying that they want a bit of respite from that space. But systems and reporting, payroll, central all hate them, because they mess up the structure, the structure's not clean, it's messy.* – Interview participant 2

Psychological wellbeing service

DJCS participants reported the Psychological Wellbeing Service (PWS) to be a highly valued and recommended support. PWS is a psychology services for DJCS employees in specified roles that focuses on the management and prevention of vicarious trauma and burnout. Participants explained the value of the service was due to its accessibility (no limitations on use), its effectiveness in identifying and addressing vicarious trauma and its understanding of the work context. Mandating a minimum number of sessions and further information on how to access the service was identified by participants as possible methods to promote use.

> *PWS used to be mandatory – I am all for that. And I think it's a double-ended sword. I think people should have the desire to do it themselves. But I also think it would be a good push for people that probably would be closed off to that sort of thing, and just to have that monthly, or however often – I just think that would benefit the team as well… it would assist with burnout and stuff like that.* – Focus group 2, participant 2

Considerations

- Strategies that were found to have some effectiveness by the pilot require further testing to establish process for implementation and effectiveness in other departments and services.

Strategies identified for further investigation

Due to an array of limitations, a number of strategies identified by stakeholders during the pilot could not be implemented or were implemented and no data was collected on their implementation and effectiveness. Despite the lack of data, select strategies have been summarised below to provide the impetus for further testing. The inclusion criteria for strategies in Table 8 was based on one or more of the following:

- Directly addresses a gap or limitation identified by the pilot
- Aligns with the research on organisational prevention of vicarious trauma
- Aligns with MHIF funding objectives
- Identified by multiple stakeholders or sites as a strategy worth implementing

Table 8. Prevention strategies that require further work to establish their effectiveness

Strategy	Function
Increase availability of vicarious trauma resources	Making vicarious trauma resources readily available to staff would contribute to the vicarious knowledge base within the organisation and provide those most at risk with information on supports available to them. Shared drives or online training platforms were commonly identified as the best place for such resources. Resources provided by the project team were added to the online training platform for one pilot site.
Organisation-level wellbeing Key Performance Indicators	While the array of wellbeing supports and activities on offer at pilot sites were highly valued by focus group participants, the focus group engaging in these was not always a priority at the individual and organisational level. Health and wellness Key Performance Indicators were discussed as a method to encourage participation in wellbeing activities. *"The morning tea we had this morning was because we hit all our KPIs in April. If there was that kind of celebration, if we were all addressing mental health or trauma or stuff like that, I think it would just be a world of difference… So it's just interesting to see what is celebrated. And if we could put mental health on that same pedestal, it would be amazing."* – Focus group 2 participant 4
Data collection on exposure to traumatic content	A simplified vicarious trauma 'reporting system' was proposed to help managers and supervisors monitor the wellbeing of staff and provide support and intervention proportional to the level of exposure. This would also contribute to the collection of accurate data on exposure to traumatic content and its impacts. *"It's only an idea, but I think most of our role relates around making file notes in our computer system, recording information… maybe just there's a tick box after the call is*

Strategy	Function
	finished or the contact and you just tick on there whether there was a certain level of vicarious trauma or whatever it is and you can just rate it one to 10. Something of that nature. You don't want to make it an extra layer of complexity in our role. I would hate to think I've got to consult with this manager or that manager for every type of traumatic situation." – Focus group 3, participant 1
Vicarious trauma risk assessment by role	A vicarious trauma risk assessment that screens each role for sources of exposure and characteristics of exposure could help to determine the level of vicarious trauma risk associated with the role. This information can then be used to inform the design and scope of the role as well as the appropriate level supports needed for those who undertake the role.
Vicarious trauma activities sheets	Activities sheets with information or facilitated exercises that could be printed out were recommended for inclusion in the toolkit. Managers and staff could use these to facilitate discussion and a deeper and/or shared understanding of vicarious trauma.
Family support forum	Information sessions targeting staff primary support networks, such as their partner/s, adult children, parents etc, can educate family members on vicarious trauma risks, symptoms, and support strategies.
Content warnings	Content warnings that identified triggering or distressing content acknowledged the risk inherent in the work and increased awareness for staff exposed. This also empowered staff to control exposure and where necessary organise support prior, during, or after exposure.
Review sources of preventable exposure	While most occasions that involved exposure to traumatic content were essential to the delivery of services, there are incidences that are commonly overlooked. For example, participants explained photos and victim impact statements were sometimes unnecessarily included in case files. Discussing traumatic content in open-plan offices was another source of non-essential exposure. Working with staff to regularly identify unnecessary exposure can reduce the risk inherent in the work.

Considerations

- The pilot found a number of strategies could potentially contribute to the prevention effort, however evidence of the effectiveness needs to be established. Once a strategy is confirmed as effective, resources will be required to support their implementation.

CONCLUSION

The VTPAT pilot aimed to develop and test a toolkit website that supported Victorian Government Departments to prevent vicarious trauma and create safer working environments for Victorian Public Sector employees. The evaluation aimed to examine the effectiveness of the website and its three core components:

- The action planning process that supported pilot sites to implement a context-specific response
- Vicarious trauma information and resources, including a training framework
- Prevention strategies that focuses on organisation-level prevention

Findings from the evaluation show the pilot and resultant toolkit took a novel and much-needed approach to preventing vicarious trauma. Although the effectiveness of the website could not be determined by the pilot; by targeting at-risk workers and organisation-level prevention, the toolkit was found to be addressing an identified need. The evaluation found the action planning process tested by pilot sites had a number of strengths and limitations that resulted in mixed success. Modifications to the process are recommended prior to future use. A training framework, framing exposure to traumatic content as a hazard was found to address a common knowledge gap among VPS employees and have early evidence of success. Strategies identified or implemented via the action planning process undertaken by pilots have the potential to effectively prevent vicarious trauma. Further investigations of the effectiveness and implementation is warranted. Complimented by further research, the evaluation and the toolkit present an opportunity for the Victorian Government Departments and trauma organisations to acknowledge the risk inherent in trauma work and implement a proactive approach to the prevention of vicarious trauma. Considerations for future action are listed below.

Considerations for the toolkit website:

- Given the level of risk and lack of primary prevention initiatives identified in the pilot sites, it is important to establish and implement effective organisation-level prevention strategies to protect staff exposed to trauma content from mental injury.
- Organisations need to collect qualitative to accurately determine risk and impacts associated with exposure to traumatic content.
- Further research will need to be conducted to ascertain whether the redesigned website is useable and contributes to the prevention of vicarious trauma.

Considerations for the action planning process:

- Given the numerous limitations identified, the working group model is not an appropriate format for driving the action planning in pilot sites. Further research is needed to develop an approach that balances the strengths and limitations identified, including one that:
    - targets organisational level prevention
    - has equal representation with balancing of department staff
    - is informed by lived experience and mixed methods data
    - is adequately resourced
    - ensures participating staff are upskilled via introductory training
    - facilitates contribution from subject matter experts
    - can be sustainably and flexibly implemented, and
    - ensures department-wide accountability

- Key stakeholders to be provided training on vicarious trauma and exposure to traumatic content as a hazard prior to implementing the action planning process.
- Consider creating positions (at the site, department and/or organisation level) that includes a vicarious trauma champion and related activities in the position description and responsibilities.
- Redesign website to include recommendations and information to promote the collection of qualitative data.
- Modification of the VT-ORG survey to be used as a vicarious trauma prevention audit. Each survey question could be scored by an OHS or management representative based on the current prevention activities. The results of the audit could then be translated into a vicarious trauma action plan. This could be complemented by follow-up data collection using the VT-ORG as a survey combined with qualitative methods to assess effectiveness of the action plan over time.
- The use of the redesigned toolkit by VPS department and sites could be supported or facilitated by vicarious trauma subject matter experts.
- Department wide training on vicarious trauma is required to ensure all staff understand the risk of exposure to traumatic content, the organisations responsibilities to protect staff and the individual and organisation-level prevention strategies that are available.

Considerations for the vicarious trauma resources:

- VPS develops a comprehensive vicarious trauma prevention framework that promotes a shared understanding vicarious trauma as an OHS risk.
- Training on vicarious trauma is needed for staff involved in the provision of frontline services, both directly and indirectly. To be successful, the training needs to include a shift in focus from individual-level to organisation-level prevention and frame vicarious trauma as an occupational health and safety concern.
- Staff involved in the action planning process may require additional training on vicarious trauma to support their role in implementing prevention strategies.
- Learnings from the training pilot can contribute to the development of a training framework that can be reliably implemented and tested.
- Organisations collaborate with tertiary and training institutions to ensure that qualifications that lead to front line service delivery include vicarious trauma education that frames vicarious trauma as a workplace hazard.

Considerations for the prevention strategies:

- Given the benefits of reflective practice reported by participants, continuation and expansion of the facilitated sessions could be of benefit to all staff. Investigation is needed on how to promote and encourage staff to participate.
- Due to time constraints, the pilot did not collect data on long-term impacts of reflective practice in pilot sites. Further work is needed to determine whether the early impacts are sustained over time.
- Given the early indication of good outcomes from formalising discussions on vicarious trauma, the actions and targeted approach documented above could be rolled-out across the department and in other VPS roles with vicarious trauma risks.
- Strategies that were found to have some effectiveness by the pilot require further testing to establish process for implementation and effectiveness in other departments and services.
- The pilot found a number of strategies could potentially contribute to the prevention effort, however evidence of the effectiveness needs to be established. Once a strategy is confirmed as effective, resources will be required to support their implementation.

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